BEFORE THE ARIZONA MEDICAL BOARD

In the Matter of

MALCOLM G. WILKINSON, M.D.

Holder of License No. 21001
For the Practice of Allopathic Medicine
In the State of Arizona.

Case No. MD-02-0820

CONSENT AGREEMENT FOR LETTER OF REPRIMAND

CONSENT AGREEMENT

By mutual agreement and understanding, between the Arizona Medical Board ("Board") and Malcolm G. Wilkinson, M.D. ("Respondent"), the parties agreed to the following disposition of this matter.

1. Respondent acknowledges that he has read and understands this Consent Agreement and the stipulated Findings of Fact, Conclusions of Law and Order ("Consent Agreement"). Respondent acknowledges that he has the right to consult with legal counsel regarding this matter and has done so or chooses not to do so.

2. Respondent understands that by entering into this Consent Agreement, he voluntarily relinquishes any rights to a hearing or judicial review in state or federal court on the matters alleged, or to challenge this Consent Agreement in its entirety as issued by the Board, and waives any other cause of action related thereto or arising from said Order.

3. Respondent acknowledges and understands that this Consent Agreement is not effective until approved by the Board and signed by its Executive Director.

4. All admissions made by Respondent are solely for final disposition of this matter and any subsequent related administrative proceedings or civil litigation involving the Board and Respondent. Therefore, said admissions by Respondent are not intended or made for any other use, such as in the context of another state or federal government

regulatory agency proceeding, civil or criminal court proceeding, in the State of Arizona or any other state or federal court.

5. Respondent acknowledges and agrees that, although the Consent Agreement has not yet been accepted by the Board and issued by the Executive Director, upon signing this agreement, and returning this document (or a copy thereof) to the Board's Executive Director, Respondent may not revoke his acceptance of the Consent Agreement. Respondent may not make any modifications to the document. Any modifications to this original document are ineffective and void unless mutually approved by the parties.

6. Respondent further understands that this Consent Agreement, once approved and signed, is a public record that may be publicly disseminated as a formal action of the Board and will be reported to the National Practitioner Data Bank and to the Arizona Medical Board's website.

7. If any part of the Consent Agreement is later declared void or otherwise unenforceable, the remainder of the Consent Agreement in its entirety shall remain in force and effect.

Malcolm G. Wilkinson, M.D. DATED: 8/6/2003

FINDINGS OF FACT

1. The Board is the duly constituted authority for the regulation and control of the practice of allopathic medicine in the State of Arizona.

2. Respondent is the holder of license number 21001 for the practice of allopathic medicine in the State of Arizona.

3. The Board initiated case number MD-02-0456 after it received a complaint regarding Respondent's care and treatment of a 63-year old female ("P.J.").

4. On September 23, 2002, P.J. presented to Respondent for an evaluation of abdominal pain symptomatic of gastric distress. P.J.'s primary care physician ("PCP") referred her to Respondent for a surgical evaluation for possible biliary dyskinesia.

5. Respondent noted that P.J. received little relief with antacid medication or diet change. He also noted that P.J. had an abdominal ultrasound performed in January 2002, and the ultrasound test was interpreted as normal.

6. Based upon P.J.'s medical history and failed past treatment, Respondent recommended that P.J. undergo an endoscopy and a nuclear dimethyl hydroxyiminodiacetic acid ("HIDA") scan to further evaluate her complaints.

7. On October 10, 2002, Respondent performed an upper endoscopy. During the procedure, Respondent performed a biopsy of the distal antrum. The endoscopy test results revealed gastritis and the biopsy results revealed the sample was negative for urease production. The same day, P.J. underwent a nuclear medicine HIDA scan which showed a reduced ejection fraction of the gallbladder.

8. According to P.J., she was never notified of any of the test results. P.J. continually called Respondent's office for the test results and never received a return call.

9. On November 18, 2002, the PCP called Respondent's office to obtain P.J.'s test results. According to Respondent's staff, they would fax P.J.'s test results as soon as they could find her chart.

10. On November 20, 2002, Respondent's office received a second call from the PCP requesting P.J.'s test results. Respondent's staff again stated when they found P.J.'s chart that they would fax the information to the PCP.

11. On December 20, 2002, the PCP called Respondent's office again requesting the test results. Respondent's staff told her that P.J.'s test results would be faxed. The PCP never received P.J.'s test results from Respondent's office.

12. In January 2003, P.J. was able to obtain her test results from the medical facility where her endoscopy and HIDA scan were performed.

13. Respondent admitted there was no documentation in the office chart concerning the calls made by P.J. or her PCP. Respondent also admitted that the way his office handled this situation was not acceptable.

14. Respondent stated he recalled speaking to P.J. at the hospital and leaving a message for her concerning the results. Respondent states he advised P.J. to follow-up with his office concerning the need for a possible cholecystectomy. He also indicated to his staff that this was the recommendation he wanted the staff to relay to P.J. on return phone calls. Respondent's chart entries do not reveal any evidence that indicated P.J. was notified of her test results.

15. Respondent stated that he realized it was his responsibility to appropriately inform P.J. and her referring physician of the results concerning consultations and treatment recommendations.

16. A Board Medical Consultant reviewed this case and opined that the standard or care required Respondent to timely inform P.J. of her test results.

17. Respondent failed to meet the standard of care when he did not timely notify P.J. of her test results or respond to her numerous telephone calls requesting the test results.

18. P.J. was potentially harmed because failure to timely notice test results may have resulted in a delay in diagnosis and treatment, persistent symptoms, and progression of disease.

CONCLUSIONS OF LAW

1. The Board possesses jurisdiction over the subject matter hereof and over Respondent.

2. The conduct and circumstances described above constitute unprofessional conduct pursuant to A.R.S. § 32-1401(24)(q) – ("[a]ny conduct or practice that is or might be harmful or dangerous to the health of the complainant or the public.").

ORDER

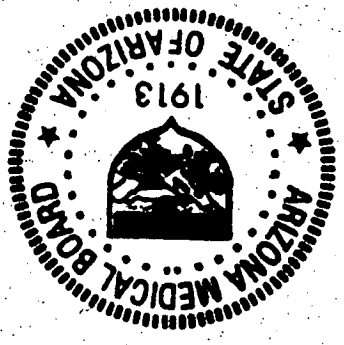
IT IS HEREBY ORDERED THAT:

1. Respondent is issued a Letter of Reprimand for failure to timely notify the patient of the test results and respond to the numerous telephone calls made by the patient.

2. Respondent shall pay a civil penalty in the amount of $1000.00 within 60 days.

3. This Order is the final disposition of case number MD-02-0820.

DATED AND EFFECTIVE this 11th day of September, 2003.



ARIZONA MEDICAL BOARD

By _____
BARRY A. CASSIDY, Ph.D., PA-C
Executive Director

ORIGINAL of the foregoing filed this 12th day of September, 2003 with:

Arizona Medical Board
9545 E. Doubletree Ranch Road
Scottsdale, AZ 85258

EXECUTED COPY of the foregoing mailed by Certified Mail this 12th day of September, 2003 to:

Malcolm G. Wilkinson, M.D.
300 S. Willard Street, Suite 101
Cottonwood AZ 86326-4160

EXECUTED COPY of the foregoing hand-delivered this 12th day of September, 2003, to:

Christine Cassetta, Assistant Attorney General
D.K. Keenom, Division Chief, Investigations
Sandra Waitt, Management Analyst
Arizona Medical Board
9545 E. Doubletree Ranch Road
Scottsdale, AZ 85258

Brenda Hall
Board Operations